

**STATE OF MARYLAND
FAMILY AND MEDICAL LEAVE
RETURN TO WORK MEDICAL CERTIFICATION FORM**

(Type or Print)

PART I EMPLOYEE INFORMATION

①

Name:

Social Security Number:

②

Title:

Department:

③

Date Leave Commenced:

④

Date of Return to Work:

⑤

Employee's signature: _____ Date: _____

PART II TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

⑥ *I certify that on _____ (date), I examined _____ (name of employee), and on the basis of my examination, this employee is ready to return to work and is able to perform the functions of his/her position.*

Signed: _____ Date: _____

⑦

Health Care Provider's Name, Address, and Telephone Number:

PART III TO BE COMPLETED BY EMPLOYER

Employer Remarks:

This form should be delivered or mailed to:

